

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Newton, a prisoner at HMP Five Wells, on 31 December 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. On 8 July 2024, Mr Dean Newton was sentenced to five years in prison for sex offences. On 31 December 2025, Mr Newton died of a myocardial infarction (a heart attack), while a prisoner at HMP Five Wells. This was caused by coronary artery thrombosis (a blood clot which blocks the artery around the heart). Mr Newton also had hypertension (high blood pressure) which did not cause but contributed to his death. Mr Newton was 52 years old. We offer our condolences to his family and friends.
4. The Ombudsman's office wrote to Mr Newton's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer, to review Mr Newton's clinical care at HMP Five Wells.
6. As part of the investigation, the PPO investigator and the clinical reviewer interviewed one member of healthcare staff. The interview transcript is attached to this report.
7. The clinical reviewer concluded that the clinical care Mr Newton received at Five Wells was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She found that healthcare staff did not address Mr Newton's obesity or discuss treatment options with him. She made two recommendations which are not related to Mr Newton's death but which the Head of Healthcare will want to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Newton's care.
9. We did not identify any non-clinical issues of concern. We make no recommendations.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. At an inquest held on 22 July 2026, the Coroner concluded that Mr Newton died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

August 2026



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